OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **QUEE FAH CHIN, M.D.,** **Respondent.**	**Case No. 24-10433-1**

FILED
APR 26 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Quee Fah Chin, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 7285). Respondent was originally licensed by the Board on October 27, 1994.

2. Patient A[2] was an eighty-one (81) year-old male at the time of the events at issue.

3. On January 10, 2020, Patient A underwent heart valve replacement surgery at a hospital. After the procedure, Patient A required an exploratory laparotomy for an ischemic bowel obstruction, with small bowel resection and right colectomy with ileostomy.

4. After the procedure, Patient A developed an abdominal wound dehiscence with infection. Patient A then underwent an open debridement of his abdomen with wall washout and

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Col. Eric D. Wade, USAF (Ret.), and Carl N. Williams, Jr., M.D.

[2] Patient A's true identity is not disclosed herein to protect his privacy but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

wound closure and was transferred to Wellbrook Centennial Hills (Wellbrook) on February 6, 2020, for medical and wound care management. At the time, his abdominal wound was noted to be open and draining.

5. Additionally, after being transferred to Wellbrook, Patient A's attending physician planned to continue Patient A's transfer medications, including antibiotic and antifungal.

6. During Patient A's stay at Wellbrook his condition worsened, and he developed fecal contamination of his abdominal wound.

7. Respondent first saw Patient A on or about February 10, 2020, for wound care follow-up consultation. Respondent noted a large open surgical wound in the midline with noticeable necrotic fatty tissue, and a mild odor. Respondent also noted that an infected wound may have caused the dehiscence.

8. Respondent saw Patient A again on February 12, 2020, noted a mild odor, and planned to place Patient A on negative-pressure wound therapy later that day. An infectious disease physician also saw Patient A on February 12, 2020, and continued Patient A on antibiotics.

9. On February 24, 2020, Respondent saw Patient A, noted a foul odor and an infected wound, and noted a concern about an enterocutaneous fistula (fistula). Respondent did not contact the infectious disease specialist who previously consulted with Patient A at Wellbrook. Respondent did however recommend a surgical evaluation after noting his concern about a fistula.

10. Patient A's abdominal wound continued to increase fecal output after February 24, 2020. Respondent saw Patient A again on February 26, 2020, and March 2, 2020, and both times noted concern over a fistula developing.

11. On March 4, 2020, Respondent noted that a surgeon had conducted an evaluation of Patient A, but that the surgeon did not provide any comments about a fistula. Because the fistula was not noted, the surgeon recommended to stop the total parenteral nutrition, resume feedings, and continue off antibiotics.

12. Respondent met with Patient A multiple times between February 12, 2020, and March 4, 2020. During this timeframe, multiple labs were taken, showing abnormal findings

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which possibly indicated developing inflammation and/or infection, such as elevated white blood cell count (leukocytosis) and neutrophilia, elevated c-reactive protein, and elevated erythrocyte sedimentation rate. However, Respondent did not acknowledge these abnormal lab findings in his notes or document evaluation of the labs.

13. Respondent's notes further did not at any time indicate a recommendation or order for a computed tomography (CT) scan to confirm the presence of the fistula, despite documenting concern over the fistula.

14. Respondent's notes further did not indicate any personal communication or consultation with the infectious disease specialist, the surgeon, or the attending internal medicine physician, regarding Patient A's fistula, abdominal abscess, and/or abdominal wound infection.

15. On March 7, 2020, Patient A was found unresponsive and transferred to the hospital. Patient A's vital signs taken that day, including elevated temperature, low blood pressure, and high heart rate, were consistent with sepsis.

16. Patient A was pronounced dead later that day, and the cause of death was noted as cardiopulmonary arrest due to or as a consequence of an unknown etiology.

COUNT I

NRS 630.301(4) - Malpractice

17. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

18. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

19. NAC 630.040 defines malpractice as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

20. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A, by (1) failing to acknowledge or evaluate multiple abnormal laboratory findings taken on or about February 26, 2020, March 2, 2020, and

March 4, 2020, which were suggestive of a worsening infection; (2) failing to personally communicate with the other physicians involved in Patient A's care, regarding Patient A's condition and/or treatment of his fistula, including but not limited to the infectious disease physician and the surgeon; and (3) failing to obtain abdominal imaging to further evaluate the presence of Patient A's fistula or abdominal abscess.

21. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) – Failure to Maintain Complete Medical Records

22. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

23. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

24. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document his actions when he treated Patient A, whose medical records were not accurate and complete. Specifically, Respondent's medical records did not acknowledge multiple abnormal laboratory findings suggestive of a worsening infection and did not document Respondent's personal communication with the other physicians involved in Patient A's care.

25. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT III

NRS 630.306(1)(b)(2) – Violation of Standards of Practice Established by Regulation

26. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

27. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

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28. NAC 630.210 requires a physician to "seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services."

29. Respondent failed to timely seek consultation with another provider of health care, such as an infectious disease specialist or a surgeon, regarding Patient A's medical condition from February 12, 2020, to March 4, 2020, in order to address the doubtfulness of Patient A's diagnosis. Such a timely consultation may have enhanced the quality of medical services provided to Patient A regarding his fistula and abdominal wound infection.

30. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 26th day of April, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

WILLIAM P. SHOGREN
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 26th day of April, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

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